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SYMPOSIUM: CLINICAL RISK AND JUDICIAL REASONING

Limiting Exposure to Medical Malpractice Claims and Defamatory Cyber Postings via Patient Contracts

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Abstract The documents patients sign on admission to a medical practice can constitute a legal contract. Medical practices around the country are attempting to use these documents as a prospective defense against medical malpractice claims. Protective contractual provisions are often attacked on grounds that they are legally void as a result of unconscionability. Widespread use of arbitration clauses have been met with mixed success. Arbitration clauses that limit damages available in medical negligence cases have been stricken in some states as having provisions that impose excessive entry costs on a patient starting the arbitration process. Other provisions relating to prequalification requirements for expert witnesses are now being used with increasing frequency. Clauses have even been placed in patient contracts that address cyber postings of adverse claims against physicians. Prospective patient contracts may be an effective means to limit exposure to medical malpractice lawsuits and to minimize defamatory cyber postings.

Introduction

A patient's first encounter with a physician's practice is often a stack of forms to be completed. Basic demographic information is followed by details of the medical history. Finally, there are the inevitable questions concerning insurance coverage, assignment of benefits, and a statement of financial responsibility. With increasing frequency, the standard forms are being supplemented with new clauses to set forth ground rules for disputes that may arise in the future between the patient and his or her physician.

In response to practicing medicine in a time of substantial medical malpractice litigation and Internet-based information, many healthcare providers are looking to contracts as a method of protection against litigation. Provisions prohibiting legal claims, compelling arbitration, limiting potential damages, qualifying future expert witnesses, and prohibiting Internet postings all have been deployed with varying rates of success.

Some of the issues discussed here have previously been addressed in publications by the authors. Contract enforceability issues were highlighted in "Contracts to Prevent Frivolous Suits," For the Defense, September 2005 [13]. Some information in the current article, including content and procedures for patient-physician contracts as well as a discussion of unconscionability, is in an updated and revised form. More recently, the authors reviewed the use of arbitration clauses in "Arbitration and Other Protective Clauses in Long Term Care Admissions Agreement" in Health Lawyers News, May 2008 [2]. This article draws on some of the case law references used in this prior article relating to the enforceability of arbitration clauses. However, this discussion incorporates additional case law and looks to the wider applicability of arbitration clauses in healthcare agreements. The emerging problem for physicians of web-based claims of substandard care or malpractice has not been presented in a journal by either author before this publication. This new terrain will become a place of difficulty and anxiety for many medical providers

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in the future as physician "rating" web sites proliferate and more patients turn to the Internet for medical guidance and personal venting. The common theme is that contracts, upfront, can be more effective in preventing a number of medicolegal problems than after-the-fact remedies.

This article describes what a contract is and what makes it enforceable and then describes specific types of contracts and contract elements presently being used by some in the medical community to minimize the risk of malpractice suits.

What Is a Contract?

Although it sounds like a straightforward question, it has no easy answer. According to law professors Calamari and Perillo, no entirely satisfactory definition of the term "contract" has ever been devised [5]. A contract is generally viewed as a legally enforceable agreement between parties.

What Provisions of Contracts With Patients Are Enforceable?

What types of contracts with patients will not work? Asking a patient to forego all remedies will not be enforced by courts. "Most jurisdictions have ruled that physicians and hospitals cannot require patients to waive their rights to recover damages for medical malpractice" states New York University School of Law Professor Jennifer Arlen [9]. Public policy concerns mandate that a patient needs to have some remedy for harm received by another's negligence. Having patients sign a blanket release that absolves a physician of all liability is considered abusive by courts, and such agreements have been routinely dismissed.

If the demands of a contract are narrower, the contract will more easily withstand challenges to enforceability. Establishing contracts between physicians and patients requires substantial foresight. Restriction or exclusion of legal rights may render a contract unenforceable. The system for resolution of differences should be the focus of the contractual terms, not a limitation of legal remedies. For example, a term which, in the event of a patient-physician dispute, requires both parties to exclusively use experts who are members of and follow the code of ethics adopted by a medical specialty society is likely enforceable.

To increase the likelihood that a court will enforce an agreement, the following seven points should be followed:

(1) The mutuality of the agreement is important; mutual assent of the contracting parties is mandatory in contract law.

(2) The agreement should not make any attempt to limit the liability of the physician or to change the nature of the physician's duty to the patient. For example, no attempt should be made to contractually lower the standard of care a patient is to receive. Often a distinction is made between ordinary negligence and gross negligence. Ordinary negligence as it relates to standard of care is failure to do what a reasonably prudent specialist would do in the same or similar circumstances. Gross negligence is defined many ways, but one definition is wanton disregard for the safety of the patient (ie, performing surgery after drinking six cocktails). An agreement to limit a remedy only to gross negligence (foreclosing any remedy based on ordinary negligence) would likely be successfully challenged.

(3) Whether the agreement stands alone or is part of another agreement, there should be a definite method of calling attention to these provisions. If the agreement is part of a larger agreement, making the print somewhat larger or bolder would be helpful to make it stand out. If embedded within an existing form, the contractual terms of interest should not appear hidden or buried to a reasonable person. The relevant terms should be conspicuous. Although some states mandate that arbitration agreements, for example, print the important terms in a particular typeface (such as YOU ARE WAIVING YOUR RIGHT TO A JURY TRIAL in bold and capital letters), such statutory restrictions are the exception rather than the rule.

(4) The contract should be presented to the patient, whenever possible, in sufficient time to give the patient ample opportunity to think about the contract and its consequences and to ask questions about it. It is advisable to have a standard office procedure for presenting the contract to the patient that is consistent and fair. For example, office policy should be to ask if the patient had an opportunity to read the agreement and if he or she had any questions about the agreement. The agreement should be dated by the patient at the time of signing.

(5) If the agreement is obtained when the medical care is needed on an urgent or emergent basis, a court may deem the contract to be unconscionable. A better approach would be to obtain an agreement after the fact (that is, after the emergent or urgent situation has abated such as a posthospitalization office visit) and make the agreement retroactive to include the urgent and emergent care. If this is done, the date of the execution of the agreement should be clearly recorded.

(6) It is probably not appropriate to condition treatment on the signing of the agreement even in nonurgent or nonemergent settings; in such situations, a court may find that one party signed the contract under duress.
(7) When a patient is given the opportunity to ask questions, the person being asked questions must be knowledgeable and respond in a meaningful way. The physician, of course, would be the ideal person. Alternatively, an office representative can substitute if he or she is reasonably trained and capable.

Enforceability

One test that will determine enforceability is whether the document is a contract of impermissible adhesion. An adhesion contract is "a standardized contract, which, imposed and drafted by the party of superior bargaining strength, relegates to the subscribing party only the opportunity to adhere to the contract or reject it [24]." Although "adhesion contract" is usually viewed as a pejorative label for an agreement, one court has recognized the basic truth that the vast majority of all contracts in the United States fit the description of adhesion contract [18]. The important task is to distinguish which adhesion contracts are appropriate and therefore enforceable and which are not.

The usual term to describe the unenforceable adhesion contract is "unconscionable." This concept is described in various ways. In Sanford v. Castleton Medical Center, the court described an unconscionable contract as one in which a great disparity in bargaining power exists between the parties such that the weaker party is made to sign a contract unwillingly or without being aware of its terms. The court remarked that to be unconscionable, the contract must be such as no sensible man not under delusion, duress, or in distress would make and such as no honest and fair man would accept.

Unconscionability is very much a fact-sensitive and case-by-case finding. There are two aspects to unconscionability, procedural and substantive [27]. The procedural aspect refers to the way the contract is reached. For example, did the patient have time to review the agreement in an elective setting or was the agreement presented while the patient was supine on a gurney, in a hospital gown, being wheeled to the surgical suite? The latter is more likely to be deemed procedurally unconscionable. Substantive unconscionability refers to the actual terms of the written contract. Both are important.

It seems likely certain provisions of an agreement would pass judicial review and not be deemed substantively unconscionable. Such provisions would include: (1) the promise not to bring a frivolous lawsuit; and (2) the mutual promise to use as an expert at trial who is only a physician who practices the same specialty and who follows the code of ethics for his or her medical specialty society.

The first provision could be "unconscionable" only if the court concludes it is intended to have a chilling effect on bringing lawsuits that, the argument would state, is against public policy. Such a promise, however, is nothing more than an obligation already imposed on litigants through statute or common law. This principle is reflected in various types of statutes. For example, an Indiana statute permits the winning party to recover an amount of attorney fees if the losing party's suit was frivolous [17].

The second provision focuses on how evidence may be brought forward. A well-reputed treatise on contract law has noted there is a growing tendency for courts to uphold the right of parties to prescribe certain rules of evidence should a lawsuit arise out of the bargain between them so long as it does not unduly interfere with the inherent power and right of the court to consider relevant evidence [28]. If a generic term, when implemented in practice, is deemed too restrictive, a court might refuse to enforce that term. For example, if the term is "each expert must be a member of the American Association of Orthopaedic Surgeons," the plaintiff is afforded a universe of options. There are many members in that society, and most orthopaedic experts for a plaintiff or defendant are likely already members of that society. On the other hand, if the term only allows for experts who are members of a much smaller group, for example, one with 30 members, that term might functionally prevent a plaintiff from ever finding an expert to prosecute his or her case. In that case, the term might be stricken. The less restrictive the term, the greater likelihood of surviving a challenge.

Arbitration Clause

The most common contractual provision being used by healthcare providers today to address medical malpractice litigation is an arbitration clause. Predispute binding arbitration agreements are contracts in which both the physician and the patient give up access to a jury trial and traditional court setting. In arbitration, medical malpractice claims are decided by an individual or panel of qualified arbitrators [10]. Arbitration provides a faster, less emotional, and more predictable alternative to the traditional jury trial.

Courts around the country have been enforcing arbitration provisions in patient contracts. Carolyn Mason signed a contract when admitting herself into a nursing home in Vicksburg, MS, in 2003. In the first few days of her stay at the nursing home, she was attacked and injured by another resident of the facility. In 2004, Mason filed suit in a

Mississippi State Court. The nursing home moved to compel binding arbitration pursuant to the terms of Mason's agreement. On October 9, 2007, a Mississippi Appeals Court ruled the agreement was enforceable and applicable to Mason's claims of negligence [8].

Shortly after the decision in the Mason case, the US District Court for the Northern District of Mississippi enforced an arbitration agreement in a more extreme situation. Dora Gulledge signed an arbitration agreement on behalf of her mother, Luanna Campbell, during her admittance to a nursing home. Campbell was illiterate, partially blind, and had serious medical conditions at the time of her admission. Here, the court found that the arbitration agreement was not procedurally unconscionable because it used understandable language and dealt solely with arbitration. The court went on to hold that the agreement did not violate any right that a party may have simply selected the forum in which the parties agreed to handle their disputes [16].

Others have attempted to enforce more substantive than procedural agreements within arbitration agreements. The Montana-based firm, Obstetricians Gynecologists Risk Retention Group of America (OGRRGA), has its insured physicians use patient contracts that limit noneconomic damages (pain and suffering) to no more than $250,000. The group's web site states "Binding Arbitration is at the heart of OGRRGA's program, promoting a healthier patient-physician relationship while greatly helping to reduce risk of practicing medicine [22]." The Florida Medical Association has a waiver form for its members that would cap noneconomic damages at $250,000 [12]. Whether agreements to limit noneconomic damages associated with arbitration agreement will be enforced by courts remains an open question.

It seems clear there is a strong desire by some to contract around the inefficient and unpredictable nature of the jury system. James Wootton, a Washington, DC-based attorney, has promoted a model called NationsCourt. NationsCourt seeks to create a "justice system that will be a better compliment to the healthcare systems they are meant to support." Wootton favors an approach that uses specialty judges as independent expert witnesses. The concept again calls for a predispute agreement that selects the forum and rules by which disputes will be addressed.

Agreements to Prequalify Experts

The heart of any medical malpractice claim is the expert witness. Many physicians have long believed unethical expert witness testimony supports meritless claims. Unfortunately, little could be done about deviant expert witness testimony because all witnesses have civil immunity for their testimony.

Some accountability for expert witness testimony was allowed by the US Federal Court of Appeals in the case of Austin v. American Association of Neurosurgeons, 253 F.3d 967 (7th Cir. 2001). In the Austin case, the Court permitted the AANS to sanction a member (Dr Donald Austin) for improper testimony in a medical malpractice case. After the Court found the AANS' actions acceptable, other professional specialty societies began to implement codes of ethics for their members who testify.

Medical Justice Services, Inc provides its members with contractual language to be used in patient agreements that require future expert witnesses to be members of a professional society of the same specialty as the physician [19]. This agreement sets the stage for accountability for aberrant expert witness testimony. It also helps ensure qualified expert witnesses will be used by the parties should a dispute arise.

Little to no case law exists directly on this point. Recently, the Court of Appeals of Arizona addressed a state statute that restricted medical experts to those practicing in the same specialty of medicine as a defendant physician in a medical malpractice action. The state statute was found unconstitutional under Arizona law as violating the separation of powers [26]. This case addresses which branch of government has the power to set the criteria for expert witness testimony in medical malpractice claims in Arizona. This case does not address individuals' rights to contract for expert witness standards. However, we believe a provision/contract clause to prequalify expert witnesses would be just as valid as an arbitration clause or a clause adding collection costs on delinquent accounts. It would be enforced by filing a motion with the court to exclude any expert witness who does not meet the standards agreed upon by the parties.

Some organizations such as the American Association of Orthopaedic Surgeons establish enforceable codes of Medical Ethics and Professionalism for their members who want to testify as expert witnesses [1] and assists members in sanctioning expert witnesses who have testified falsely against the member. Outside of specialty medical societies themselves, it is one of the only systems that directly address the key problem of improper expert witness testimony.

Web-based Claims of Malpractice

An emerging venue for complaints against physicians is the Internet. Web sites such as RateMDs.com [23] provide a platform for the general public to criticize doctors. The site uses metrics such as frowning faces and smiley faces and

permits anonymous postings. The complaints, no matter how unfair or inaccurate, remain indefinitely available for anyone to examine.

The traditional means of addressing this problem are legally difficult. The Communication Decency Act [7] has repeatedly been used to provide immunity for web site content for Internet service providers. For example, on May 16, 2008, the US Court of Appeals for the 5th Circuit found MySpace was immune from plaintiffs' claims of negligence because it was merely the web-based publisher of third-party information, not the author of the content. This case dealt with claims that a minor child had been sexually assaulted by a MySpace user after the site was used to convey personal information about the minor child [11]. The Communication Decency Act effectively prevents a physician from seeking remedy from an Internet service provider for defamatory comments posted on the Internet.

Medical providers still have the ability to file claims for defamation against individuals posting malicious and inaccurate comments about their medical abilities on the Internet. Often the poster is anonymous. However, even when the patient is identified with a name and address, a lawsuit alleging defamation is a difficult path to remedy an unfortunate situation. Such a path has the unintended consequence of drawing even more publicity to a delicate matter. Dr Jonathan Sykes found himself in the unenviable position of dealing with a disgruntled patient who had created a web site (mysurgerynightmare.com) attacking the medical care he had provided this patient. Dr Sykes brought a defamation claim in California against the former patient/defendant, Georgette Gilbert. A California appellate court ruled against Dr Sykes, concluding the doctor used the Internet to promote his reputation and therefore was a public figure. A public figure has a higher burden of proof and here, he did not cross that threshold. Dr Sykes' connection to the public was primarily based on the fact that his practice had a web site [14]. Even if the physician could be successful in a defamation claim, the litigation required and the uncertainty related to whether or not a judgment is collectable makes the tort of defamation an unappetizing remedy for web-based defamation.

It is theoretically possible for physicians and patients to enter, ex ante, into agreements that prohibit patients from posting comments online about a physician's medical ability. The authors know of no case law involving such contractual terms. However, it does seem possible that principles of contract law could form the basis for an enforceable legal position for prohibiting actions such as Gilbert v. Sykes as referenced here [14].

A frequent source of confusion is whether freedom of speech, including the right to post as one pleases on the Internet, is absolute. First, the Bill of Rights prevents the government from abridging speech. Physicians are generally not considered agents of the government, even when they accept reimbursement from government entities such as Medicare or Medicaid. Although free speech is a cherished value in our country, that right is not absolute. Everyone knows one cannot yell fire in a crowded theatre with impunity [25]. Likewise, fighting words and obscenity are not protected [6, 20]. To give this concept color, in 2007, the Supreme Court ruled a school could suspend a high school student for displaying the cryptic banner "Bong Hits 4 Jesus" during an Olympic parade [21].

In the American tradition, the antidote to "offensive speech" is more speech. However, health care is complex. Free speech in the medical world is balanced, in tension, with privacy obligations. On that matter, Congress has spoken. HIPAA (as well as state confidentiality laws and medical ethics) prevents a physician from posting the medical record to counter a negative post on a physician ratings site. Setting the stage upfront prevents the need to defend online, a defense that physicians could never use anyway. In that sense, mutual agreements to maintain privacy may solve the thorny issue, foreclosing the need to resort to a lawsuit of defamation.

Discussion

The initiation of most physician-patient relationships begins with the signing of agreements by the patient. Although viewed by many as simply a means to collect information from patients, these form documents offer an opportunity to protect physicians from potential future inappropriate patient behavior. Medical providers may ask patients to sign agreements that spell out how future claims of medical malpractice by the patient should be made and advanced. Theoretically, agreements with patients that prohibit future web postings and anonymous publications are possible. Additionally, ex ante agreements for future qualifications of expert witnesses for malpractice litigation may be of benefit.

Few, if any, cases have been decided directly on point. Courts do seem to be willing to enforce patient agreements in analogous situations. This discussion of arbitration clauses reveals the possibility of medical provider-patient agreements being enforced at later dates. That said, substantial legal issues still remain for physicians wanting to have patients sign protective agreements.

The law has traditionally seen that one cited unfair contractual language can be avoided by the court. The law uses the "contracts of adhesion" for this situation. Particular care must be used in assuring that contractual clauses are not overreaching and shocking to the ordinary conscious. A fundamental principle of contract law is that the court will not enforce contractual clauses that are against

public policy. It remains an open question which, if any, protective provisions of physician-patient contracts courts will find "against public policy." Additional considerations come into play when physicians attempt to use contractual provisions to prevent patients from making future publications about a physician's medical ability. Here, First Amendment issues involving freedom of speech come into play. As with many areas of "cyber law," there is little legal precedent to provide guidance. This is one of the novel issues the authors believe will be addressed by courts in the years to come.

A parallel issue to the legality of contracts to address medicolegal issues is the ethics of such agreements. Patients are already accustomed to many types of contracts. They routinely sign agreements to pay the doctor's fee. Patients remain in control, through contract, in determining who may see their protected health information. The question is how to balance the legitimate expectations of doctors and patients in the context of a meaningful relationship. If a patient, for example, values the ability to post any material on the Internet above and beyond the competence of the physician, that individual should be matched with a doctor who can meet his or her expectations. For the majority of Americans, most would prefer to be taken care of by a competent "jerk" than an incompetent diplomat. So, for most people, a term to avoid posting on the Internet will be viewed as inconsequential. Although some ratings sites such as ratemds.com boast reports on over 100,000 physicians, most physicians are tagged with at most a handful of reviews. The problem, of course, is a single negative review can be very damaging. Given that the average practitioner sees scores of patients in any given week, very few people will find the restriction onerous. For those who do, there is a simple remedy, find another physician. Physicians are free to avoid seeing a particular patient or even discharge an existing patient. There are guidelines that should be followed. For example, one should not avoid seeing a patient because of his or her race or religion. One should not discharge an existing patient until a plan is presented for adequate followup care such as transfer to another physician or referral to the County Medical Society. Patients are ordinarily free to choose their doctor, and doctors are ordinarily free to not see a particular patient. This general principle does not violate ethical norms. If contracts leave reasonable options for patients, no ethical tenet will be violated.

Derivative to the issue of the ethics of presenting such agreements is whether specific terms are unethical such as that supporting review of expert testimony by professional societies. One argument is that such review chills the environment, creating a climate of fear, making it almost impossible for a plaintiff to locate an expert to prosecute his or her case. Empirically, there is little support for this. There is a whole cottage industry built on supplying experts for a fee. A Google search using key words "expert witness" and "medical malpractice" yields just under 300,000 results. The ads accompanying the organic search suggest the climate remains hot without any hint of chill [15]. Each term, of course, has its own ethical challenges. A term that forecloses any remedy whatsoever for a negligently injured patient is one that is both legally unenforceable and ethically untenable. Terms that preserve rights, albeit with some restrictions, are on safer ethical ground.

Those seeking to do further reading on these topics may want to read "The Future of Reputation" by Daniel J. Solove [29]. A more general overview of legal concepts of contracts may be found in "Contract Examples and Explanation [3]" or "Contract Law: Selected Source Materials [4]." The law is an ever-evolving field. With a new opinion, the landscape may change overnight. Publications such as Thompson/West Publishing's "Medical Malpractice Law Report" provide, in a monthly newsletter setting, case law update regarding this topic from across the United States. Publications such as these help readers keep abreast of this dynamic area of law.

By requiring patients to agree, ex ante, to certain provisions, physicians are able to have some degree of control in handling of disputes that may arise. These provisions may include binding arbitration, caps on noneconomic damages, prequalification of expert witnesses, or even prohibitions from web posting. Based on the Federal Arbitration Act, many such contractual provisions have been found by state courts to be enforceable. Although not applicable in every situation, patient contracts do provide physicians an added layer of protection when dealing with a medical malpractice claim. Hiring experienced counsel to devise such contractual agreements may increase the likelihood of later enforceability.

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